

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6372

CERTIFICATE OF DEATH

Reg. Dist. No.

06361
181

1. PLACE OF DEATH o. COUNTY Harford MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Oklahoma b. COUNTY Comanche		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen			c. LENGTH OF STAY IN 1b 5 months		
d. NAME OF HOSPITAL (If not in hospital, give street address OR INSTITUTION) Hospital Aberdeen Proving Ground Md			d. STREET ADDRESS 3122 Faris Avenue		
3. NAME OF DECEASED (Type or print) First Melvin Middle Peter Last Baldwin			4. DATE OF DEATH Month June Day 17 Year 57		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 27 Feb 1919		9. AGE (In years last birthday) yrs. 38
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Soldier - Sgt		10b. KIND OF BUSINESS OR INDUSTRY US Army	11. BIRTHPLACE (State or foreign country) North Dakota		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Unknown		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. World War II 502-05-1191		17. INFORMANT Official US Army Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema, plural effusion 003.1 DUE TO cause undetermined Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) _____ DUE TO _____ (c) _____					INTERVAL BETWEEN ONSET AND DEATH Unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 522x					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from 17 June , 19 57 , to 17 June , 19 57 , that I last saw the deceased on 17 June 19 57 , and that death occurred at 0925 M, from the causes and on the date stated above.					
ACTUAL SIGNATURE W. Michener Capt MC M.D.			ADDRESS (Street, city or town, state) US Army Hosp APG Md		
PHYSICIAN'S NAME (Type) W M MICHENER Capt MC			DATE SIGNED 17 Jun 57		
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Removal	6/18/1957	*****		Lawton, Oklahoma.	
23. FUNERAL DIRECTOR'S SIGNATURE John G. Garrow Aberdeen Md.			24a. REC'D BY REGISTRAR DATE June 19-57		24b. REGISTRAR'S SIGNATURE Mellie R. Perry

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Manner of Death		Occupation		Signature of Physician		Signature of Registrar	
John Doe		Male		45		Jan 1, 1910		New York City		New York City		Heart Disease		Natural		Teacher		[Signature]		[Signature]	
Date of Death		Place of Death		Time of Death		Hour		Minute		Second		Day		Month		Year		County		State	
Jan 15, 1957		New York City		10:30 AM		10		30		00		15		1		1957		New York		New York	
Buried		Cremated		Interment		Place of Interment		Name of Interment		Date of Interment		Time of Interment		Hour		Minute		Second		Year	
Buried		Cremated		Interment		New York City		St. John's Church		Jan 15, 1957		10:30 AM		10		30		00		1957	
Physician's Certificate		Medical Examiner's Certificate		Coroner's Certificate		Other Certificate		Date of Certificate		Time of Certificate		Hour		Minute		Second		Year		State	
[Signature]		[Signature]		[Signature]		[Signature]		Jan 15, 1957		10:30 AM		10		30		00		1957		New York	

BUREAU V. S.

JUN 21 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

6373

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06362

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hospital</u>		d. STREET ADDRESS <u>200 N. UNION, AVE</u>	
3. NAME OF DECEASED (Type or print) <u>ARTHUR</u> <u>Arturo BRUND Beier</u>		4. DATE OF DEATH Month <u>June</u> Day <u>17</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG 1, 1923</u>
9. AGE (In years last birthday) <u>38</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>all odd jobs</u>	
11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>Germany</u>	
13. FATHER'S NAME <u>unk.</u>		14. MOTHER'S MAIDEN NAME <u>unk.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-34-1222</u>	
17. INFORMANT <u>Frank Wilbur Harre de Grace, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Drowning</u> 929.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Swimming + went under</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>6</u> p. m. <u>June 17</u> 19 <u>57</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Rodney Hood Dell</u>		20f. (City or town) (County) (State) <u>Aberdeen Harford Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Gerald C. Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Gerald C. Palmer</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> <u>Harford</u>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>County</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6-20-1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Engel & Bell</u>		22d. LOCATION (City, town, or county) (State) <u>Harre de Grace Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Madison Mitchell</u>		24a. REC'D BY REGISTRAR <u>6-20-57</u>	
ADDRESS <u>Harre de Grace Md.</u>		24b. REGISTRAR'S SIGNATURE <u>G. L. Lewis</u>	

RECEIVED

6374

CERTIFICATE OF DEATH

Reg. Dist. No.

185-

1. PLACE OF DEATH o. COUNTY HARFORD MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD b. COUNTY HARFORD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAVRE DE GRACE		c. LENGTH OF STAY IN 1b LIFE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 723 ONTARIO ST.		d. STREET ADDRESS 1723 ONTARIO ST.	
3. NAME OF DECEASED (Type or print) First SUSIE Middle HAYS Last BORROUGHS		4. DATE OF DEATH Month June Day 21 Year 1957	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 21, 1957
9. AGE (In years last birthday) 93 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	
11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME DR. GEO. T. HAYS		14. MOTHER'S MAIDEN NAME C. SUSAN HAYS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —		16. SOCIAL SECURITY NO. —	
17. INFORMANT MR. FARRAND H. BALL		Address HAVRE DE GRACE MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Seriously - Arterio Sclerosis Heart Disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Disease DUE TO (c) —		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 5, 1957 , to June 20, 1957 , that I last saw the deceased alive on June 20, 1957 , and that death occurred at 6:40 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE [Signature] M.D.		ADDRESS (Street, city or town, state) DATE SIGNED HAVRE DE GRACE, MD 6-21-57	
PHYSICIAN'S NAME (Type) A. L. Lewis		HAVRE DE GRACE, MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 22 JUNE 1957	22c. NAME OF CEMETERY OR CREMATORY ST. MARK CEM.	22d. LOCATION (City, town, or county) (State) CECIL GO. MD
23. FUNERAL DIRECTOR'S SIGNATURE R. MADISON MITCHELL		ADDRESS HAVRE DE GRACE	
24a. REC'D BY REGISTRAR DATE 6-21-57		24b. REGISTRAR'S SIGNATURE G. L. Lewis M.D.	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The low requires that the death certificate be executed within 24 hours after death. The low requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, or in any event within 72 hours after death.

BUREAU V. S.

JUN 24 1957

RECEIVED

6391

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Street Rural</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Street Rural</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Parker</u> First <u>W. Canendo</u> Middle <u>W.</u> Last <u>Canendo</u>		4. DATE OF DEATH <u>June 27</u> Month <u>June</u> Day <u>27</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 2, 1874</u>
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Heavy Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Harford Co. Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John Canendo</u>		14. MOTHER'S MAIDEN NAME <u>Hannah Scarborough</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>217-36-4402</u>	
17. INFORMANT <u>Mrs. Parker W. Canendo</u> Address <u>Street Md</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio Sclerotic Gangrene Both feet</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arterio Sclerotic C-V Disease</u> DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>239x Abdominal Tumor</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1941</u> to <u>June 27</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>June 26</u> , 19 <u>57</u> , and that death occurred at <u>6:30</u> AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Jonah A Hunt</u> M.D.		DATE SIGNED <u>Delta 82</u> <u>6/28/57</u>	
PHYSICIAN'S NAME (Type) <u>Elosiah A Hunt</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>June 29, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Emory Cem</u>	22d. LOCATION (City, town, or county) (State) <u>Harford Co. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. S. Bailey</u> ADDRESS <u>Wilmington, Md.</u>		24a. REC'D BY REGISTRAR <u>C. E. Kirk</u> DATE <u>June 28, 1957</u>	
24b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Page One

Form with multiple sections for death certificate data, including fields for name, date, and cause of death.

BUREAU V. 3

JUL 8 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

6375 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 8 Film 6217 7-5-57 et
CERTIFICATE OF DEATH

06364

Reg. Dist. No. 185

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY HARFORD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAVRE DE GRACE		c. LENGTH OF STAY IN 1b LIFE	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAVRE DE GRACE		d. STREET ADDRESS 200 S. STOKES, ST.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 200 S. STOKES, ST.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM WILSON COOLEY		4. DATE OF DEATH Month Day Year JUNE 29 1957	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1876 MAY 30, 1957
9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supt. Canning House		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (State or foreign country) MD		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME AMBROSE O. COOLEY		14. MOTHER'S MAIDEN NAME CARRIE HUGHES	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Ms. ISABEL L. COOLEY, HAVRE DE GRACE		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardio Vascular Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 422.1		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 10, 1955 , to 6-27, 1957 , that I last saw the deceased alive on June 26, 1957 , and that death occurred at 8:20 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE A. L. Lewis M.D.		ADDRESS (Street, city or town, state) DATE SIGNED HAVRE DE GRACE, MD. 7-1-57	
PHYSICIAN'S NAME (Type) A. L. Lewis		ADDRESS HAVRE DE GRACE, MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1-JULY 1957	
22c. NAME OF CEMETERY OR CREMATORY ROCKYTON		22d. LOCATION (City, town, or county) (State) HARFORD CO. MD.	
23. FUNERAL DIRECTOR'S SIGNATURE R. Madison Mitchell		ADDRESS HAVRE DE GRACE MD.	
24a. REC'D BY REGISTRAR DATE 7-1-57		24b. REGISTRAR'S SIGNATURE A. L. Lewis M.D.	

CERTIFICATE OF DEATH

PLACE IN SPACE A. CAUSE OF DEATH		B. MANNER OF DEATH	
1. Immediate Cause of Death		2. Contributing Cause of Death	
3. Underlying Cause of Death		4. Manner of Death	
5. Date of Death		6. Place of Death	
7. Name of Deceased		8. Sex	
9. Age		10. Race	
11. Marital Status		12. Occupation	
13. Usual Residence		14. Date of Birth	
15. Date of Admission to Hospital		16. Name of Hospital	
17. Name of Physician		18. Name of Attending Nurse	
19. Name of Coroner		20. Name of Medical Examiner	
21. Name of Undertaker		22. Name of Funeral Home	
23. Name of Burial Place		24. Name of Cemetery	
25. Name of Interment		26. Name of Burial	
27. Name of Burial		28. Name of Burial	
29. Name of Burial		30. Name of Burial	
31. Name of Burial		32. Name of Burial	
33. Name of Burial		34. Name of Burial	
35. Name of Burial		36. Name of Burial	
37. Name of Burial		38. Name of Burial	
39. Name of Burial		40. Name of Burial	
41. Name of Burial		42. Name of Burial	
43. Name of Burial		44. Name of Burial	
45. Name of Burial		46. Name of Burial	
47. Name of Burial		48. Name of Burial	
49. Name of Burial		50. Name of Burial	
51. Name of Burial		52. Name of Burial	
53. Name of Burial		54. Name of Burial	
55. Name of Burial		56. Name of Burial	
57. Name of Burial		58. Name of Burial	
59. Name of Burial		60. Name of Burial	
61. Name of Burial		62. Name of Burial	
63. Name of Burial		64. Name of Burial	
65. Name of Burial		66. Name of Burial	
67. Name of Burial		68. Name of Burial	
69. Name of Burial		70. Name of Burial	
71. Name of Burial		72. Name of Burial	
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87. Name of Burial		88. Name of Burial	
89. Name of Burial		90. Name of Burial	
91. Name of Burial		92. Name of Burial	
93. Name of Burial		94. Name of Burial	
95. Name of Burial		96. Name of Burial	
97. Name of Burial		98. Name of Burial	
99. Name of Burial		100. Name of Burial	

BUREAU V. S.

JUL 2 1957

RECEIVED

6392

CERTIFICATE OF DEATH

06365

Reg. Dist. No. 180

1. PLACE OF DEATH o. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Abingdon</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Abingdon</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>E. F.</u> Last <u>Cooper</u>				4. DATE OF DEATH Month <u>6</u> Day <u>8</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-20-1895</u>	
9. AGE (In years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Janitor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Aberdeen Printing Ground</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Edward Cooper</u>				14. MOTHER'S MAIDEN NAME <u>Susie Boice</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>WW1</u>		17. INFORMANT Address <u>Mrs. Ellen Cooper, Abingdon, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart disease</u> (c) <u>Arteriosclerotic Heart disease</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12/7</u> , 19 <u>51</u> , to <u>6/7</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>6/7</u> , 19 <u>57</u> , and that death occurred at <u>7:45 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>George T. Stansbury</u>				ADDRESS (Street, city or town, state) <u>569 Revolution St., Harford, Md.</u>			
PHYSICIAN'S NAME (Type) <u>George T. Stansbury</u>				DATE SIGNED <u>6/8/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-11-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Union Methodist Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Aberdeen Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Otelia J. Bullock - Harford, Md.</u>				24. REC'D BY REGISTRAR <u>June 12, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Norma S. Moore</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

For Use By

NAME OF DECEASED

MARRIAGE

SEX

AGE

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

TIME OF DEATH

CAUSE OF DEATH

PLACE OF DEATH

DATE OF INTERMENT

PLACE OF INTERMENT

DATE OF BURIAL

PLACE OF BURIAL

DATE OF CREMATION

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BUREAU V. S.

JUN 14 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial; cremation, or removal.

VS. A15ME(S)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6376

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06366

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BELAIR</u>		c. LENGTH OF STAY IN 1b <u>Few Hours</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Fresh Air Camp</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Townson</u> - 4 <u>03552</u>	
3. NAME OF DECEASED (Type or print) <u>WOOLMAN ODBORN COSTIN</u>		4. DATE OF DEATH <u>June 16</u> 19 <u>57</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 13, 1911</u>
9. AGE (In years last birthday) <u>46</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Office Mgr. Westminster Shoe Co.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>W. J. Costin</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Meredith</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>215-05-5384</u>	
17. INFORMANT <u>Mrs. Louise C. Costin</u>		Address <u>507 Woodbine Ave - 4</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Electrocution by lightning</u> DUE TO (b) <u>9354</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>Struck by Lightning</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>5</u> p. m. <u>6-16-57</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input checked="" type="checkbox"/> <u>Fresh Air Camp</u>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Bel Air</u>		20f. City or town (County) (State) <u>Hartford Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u> </u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>6-16-57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 20, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Greenmount Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HENRY SANDER & SONS, INC.</u>		ADDRESS <u>Baltimore Md.</u>	
24a. REC'D BY REGISTRAR <u> </u>		24b. REGISTRAR'S SIGNATURE <u> </u>	
DATE <u>JUN 18 1957</u>			

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

JUN 18 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6393

CERTIFICATE OF DEATH

06367

Reg. Dist. No.

185

1. PLACE OF DEATH a. COUNTY <u>Harford</u> <u>Maryland</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY <u>Harford</u> <u>Maryland</u> STATE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Churchville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Churchville, Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Robert W. Davis</u> First Middle Last		4. DATE OF DEATH <u>6/6/57</u> Month Day Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/13/1884</u> yrs. Months Days Hours Min.
9. AGE (In years last birthday) <u>73</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chemist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Comm. Ralte.</u>	
11. BIRTHPLACE (State or foreign country) <u>Philadelphia Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert W. Davis Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Elna Janett</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Mrs. Beth De Puy Davis</u> Address <u>Churchville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic C.V. Disease</u> DUE TO (c) <u>8 yrs</u>		INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>332X</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May</u> , 19 <u>57</u> , to <u>June</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>June 5</u> , 19 <u>57</u> , and that death occurred at <u>10 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. Ralph Horky</u> M.D.		ADDRESS (Street, city or town, state) <u>Churchville Md</u> DATE SIGNED <u>June 7</u>	
PHYSICIAN'S NAME (Type) <u>J. Ralph Horky</u>		<u>Churchville - Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6/8/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Washington</u>	22d. LOCATION (City, town, or county) (State) <u>Washington Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Benjamin F. H. Harky</u> ADDRESS <u>Harford County, Md.</u>		24a. REC'D BY REGISTRAR <u>6-8-57</u>	24b. REGISTRAR'S SIGNATURE <u>A. L. Lewis M.D.</u>

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

1957

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH	
JAMES EARL RAY		35		M		W		12/14/21		MEMPHIS, TENN.		MEMPHIS, TENN.		UNITED STATES	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH	
4/4/68		MEMPHIS, TENN.		MEMPHIS, TENN.		UNITED STATES		4/4/68		MEMPHIS, TENN.		MEMPHIS, TENN.		UNITED STATES	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION		MARITAL STATUS		SINGLE		MARRIED	
HEART DISEASE		NATURAL		DRIVER		HIGH SCHOOL		METHODIST		SINGLE		SINGLE		SINGLE	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH	
4/4/68		MEMPHIS, TENN.		MEMPHIS, TENN.		UNITED STATES		4/4/68		MEMPHIS, TENN.		MEMPHIS, TENN.		UNITED STATES	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH	
4/4/68		MEMPHIS, TENN.		MEMPHIS, TENN.		UNITED STATES		4/4/68		MEMPHIS, TENN.		MEMPHIS, TENN.		UNITED STATES	

BUREAU V. 3

JUN 11 1967

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										06368
Items 18-21 Film 218 8-7-57										182
6394 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No.
1. PLACE OF DEATH a. COUNTY Harford MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Harford					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fallston			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 32 Bel Air					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Fallston					d. STREET ADDRESS 1 7 Lee Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WALTER Middle Last EDWARDS					4. DATE OF DEATH Month June Day 9 Year 19 57					
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday) 51 yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Spurta, N.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Ben Edwards					14. MOTHER'S MAIDEN NAME Dora Edwards					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.		17. INFORMANT Ben Edwards Address Spurta, N.C.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowning 983X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Beaten during altercation and thrown into stream							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. 7/57 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Unknown		20f. (City or town) (County) (State) Harford Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined cause <input type="checkbox"/> .										
ACTUAL SIGNATURE Paul F. Guerin					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					DATE SIGNED 6/10/57
EXAMINER'S NAME (Type) Paul F. Guerin, M.D.										
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-14-57		22c. NAME OF CEMETERY OR CREMATORY Spurta			22d. LOCATION (City, town, or county) (State) Spurta, N.C.			
23. FUNERAL DIRECTOR'S SIGNATURE Thomas E. Nelson, Jr.				ADDRESS 1303 Preston		24a. REC'D BY REGISTRAR 6/11/57		24b. REGISTRAR'S SIGNATURE Crusella Forwood		

ALABAMA STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 3

JUN 12 1957

RECEIVED

1

INSTRUCTIONS

1 TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2 TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06369

6395

CERTIFICATE OF DEATH

Reg. Dist. No. 180

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Harford		STATE MARYLAND		STATE Maryland		COUNTY Harford	
CITY (If outside corporate limits, write RURAL OR and give nearest town) Magnolia		LENGTH OF STAY (In this place) Lifetime		CITY (If outside corporate limits, write RURAL and give nearest town) Magnolia			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location) 1			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) Mary (Middle) Elizabeth (Last) Flottesesch				(Month) June (Day) 19 (Year) 57			
5. SEX Female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married	8. DATE OF BIRTH Jan. 3, 1879	9. AGE last birthday 78 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John P. Dwaayer				14. MOTHER'S MAIDEN NAME Sarah E. Turner			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) no		16. SOCIAL SECURITY NO. none		17. INFORMANT & ADDRESS Henry J. Flottesesch Magnolia Md.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Cerebral hemorrhage						4 days	
ANTECEDENT CAUSE(S) DUE TO (B) General arterial sclerotic heart disease							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Coronary Occlusion						5 weeks	
19a. DATE OF OPERATION 3-31-57		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> A. <input type="checkbox"/> P. <input type="checkbox"/> Night <input type="checkbox"/>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 6-16 , 19 57 , to 6-19 , 19 57 , that I last saw the deceased alive on 6-19 , 19 57 , and that death occurred at 10:15 P.M. from the causes and on the date stated above.							
SIGNATURE Edw. C. Hodous				ADDRESS (Street, city, town, state) Edgewood Md.			
DATE SIGNED 6-19-57							
23. BURIAL, CREMATION, REMOVAL (Specify) Burial		DATE THEREOF June 22, 1957		NAME OF CEMETERY OR CREMATORY St. Stephens		LOCATION (City, town, or county) (State) Bradshaw, Balto., Md.	
24. REC'D BY REGISTRAR June 23, 1957		REGISTRAR'S SIGNATURE Norma S. Moore		25. FUNERAL DIRECTOR'S SIGNATURE Edward R. McClellan		ADDRESS Abingdon Md.	

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH - BOSTON

Form No. 1

1. NAME OF DECEASED (PRINT OR TYPE)

NAME
AGE
SEX
RACE
DATE OF BIRTH
PLACE OF BIRTH

DATE AND
PLACE OF DEATH

1. NAME OF DECEASED (PRINT OR TYPE)
2. NAME OF DECEASED (PRINT OR TYPE)
3. NAME OF DECEASED (PRINT OR TYPE)

4. DATE OF DEATH
5. PLACE OF DEATH

6. NAME OF DECEASED (PRINT OR TYPE)

7. NAME OF DECEASED (PRINT OR TYPE)

8. NAME OF DECEASED (PRINT OR TYPE)

9. NAME OF DECEASED (PRINT OR TYPE)

10. NAME OF DECEASED (PRINT OR TYPE)

11. NAME OF DECEASED (PRINT OR TYPE)

12. NAME OF DECEASED (PRINT OR TYPE)

13. NAME OF DECEASED (PRINT OR TYPE)

14. NAME OF DECEASED (PRINT OR TYPE)

15. NAME OF DECEASED (PRINT OR TYPE)

16. NAME OF DECEASED (PRINT OR TYPE)

17. NAME OF DECEASED (PRINT OR TYPE)

18. NAME OF DECEASED (PRINT OR TYPE)

19. NAME OF DECEASED (PRINT OR TYPE)

20. NAME OF DECEASED (PRINT OR TYPE)

21. NAME OF DECEASED (PRINT OR TYPE)

22. NAME OF DECEASED (PRINT OR TYPE)

23. NAME OF DECEASED (PRINT OR TYPE)

24. NAME OF DECEASED (PRINT OR TYPE)

25. NAME OF DECEASED (PRINT OR TYPE)

26. NAME OF DECEASED (PRINT OR TYPE)

27. NAME OF DECEASED (PRINT OR TYPE)

28. NAME OF DECEASED (PRINT OR TYPE)

29. NAME OF DECEASED (PRINT OR TYPE)

30. NAME OF DECEASED (PRINT OR TYPE)

31. NAME OF DECEASED (PRINT OR TYPE)

32. NAME OF DECEASED (PRINT OR TYPE)

33. NAME OF DECEASED (PRINT OR TYPE)

34. NAME OF DECEASED (PRINT OR TYPE)

35. NAME OF DECEASED (PRINT OR TYPE)

36. NAME OF DECEASED (PRINT OR TYPE)

37. NAME OF DECEASED (PRINT OR TYPE)

38. NAME OF DECEASED (PRINT OR TYPE)

39. NAME OF DECEASED (PRINT OR TYPE)

40. NAME OF DECEASED (PRINT OR TYPE)

41. NAME OF DECEASED (PRINT OR TYPE)

42. NAME OF DECEASED (PRINT OR TYPE)

43. NAME OF DECEASED (PRINT OR TYPE)

BUREAU V. 3

JUN 25 1957

RECEIVED

RECEIVED
BOSTON
JUN 25 1957
BUREAU V. 3

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6377

CERTIFICATE OF DEATH

0637085-
Reg. Dist. No. 185-

1. PLACE OF DEATH o. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre-de-Grace</u>	c. LENGTH OF STAY IN 1b <u>3 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>31 Aberdeen</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>		d. STREET ADDRESS <u>116 So. Park ST.</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Joseph</u> Last <u>Foulks</u>		4. DATE OF DEATH Month <u>6</u> Day <u>29</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 7th. 1876</u>
9. AGE (In years last birthday) yrs. <u>80</u>		IF UNDER 1 YEAR	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Charpentier</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Carpenter</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Orson D. Foulks</u>		14. MOTHER'S MAIDEN NAME <u>Abbie Mae Ocker</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-16-9494</u>	
17. INFORMANT <u>Madge Barnett</u>		Address <u>116 So. Park Aberdeen Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Congestive Heart Failure</u> DUE TO (c) <u>Arteriosclerotic Heart Disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs.</u> <u>3 days</u> <u>yes</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>434.1</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July</u> , 19 <u>56</u> , to <u>June 29</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>June 29</u> , 19 <u>57</u> , and that death occurred at <u>8:30 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>F. J. Hatem</u>		ADDRESS (Street, city or town, state) <u>12 N. Phila. Bldg. Aberdeen Md.</u>	
PHYSICIAN'S NAME (Type) <u>F. J. Hatem</u>		DATE SIGNED <u>6/29/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7/3/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Grove Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Aberdeen, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Tarring</u>		24a. REC'D BY REGISTRAR DATE <u>7-5-57</u>	
ADDRESS <u>Aberdeen, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>G. L. Lewis m.d.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARTLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6396

CERTIFICATE OF DEATH

06371
Reg. Dist. No. 182

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Upper Cross Roads</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Upper Cross Roads</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>		d. STREET ADDRESS <u>Fallston RD</u>	
3. NAME OF DECEASED (Type or print) <u>James William Grant</u>		4. DATE OF DEATH Month <u>June</u> Day <u>20</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 24 1898</u> 59 yrs.
9. AGE (In years last birthday) <u>59</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>3</u> Days <u>27</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Contractor</u>	
11. BIRTHPLACE (State or foreign country) <u>Upper Cross Roads Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James H. Grant</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ellen Kennedy</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, name and dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-22057</u>	
17. INFORMANT <u>Mrs Louise T Grant</u>		Address <u>Fallston Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anoxia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Bronchogenic Carcinoma & Metastases</u> DUE TO (c) <u>—</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>—</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4 MAR</u> , 1957, to <u>20 June</u> , 1957, that I last saw the deceased alive on <u>19 June</u> , 1957, and that death occurred at <u>3:45</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thos. A. E. Moseley, Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>JARRATTVILLE, Md.</u>	
DATE SIGNED <u>June 22 1957</u>		DATE SIGNED <u>June 25 1957</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 22 57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St Johns</u>		22d. LOCATION (City, town, or county) (State) <u>Hydes, Balto Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Martin E. Kutz</u>		24a. REC'D BY REGISTRAR <u>—</u>	
ADDRESS <u>JARRATTVILLE Md</u>		24b. REGISTRAR'S SIGNATURE <u>Puvilla forward</u>	

RECEIVED

JUN 28 1957

BUREAU V. S.

06372

6378

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>HARFORD</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>BEL AIR, Md</u>		LENGTH OF STAY (in this place) <u>Life</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>BEL AIR</u>		TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Thomas Run Road</u>				STREET ADDRESS (If rural give location) <u>Thomas Run Road</u>			
3. NAME OF DECEASED (Type or Print) <u>GROVER</u> (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year) <u>6 20 1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>M</u>	8. DATE OF BIRTH <u>JAN 14, 1886</u>	9. AGE last birthday <u>71</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Famer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Churchville Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James W. Hamilton</u>				14. MOTHER'S MAIDEN NAME <u>Mary Elizabeth Wood</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. <u>220-34-6109</u>		17. INFORMANT & ADDRESS <u>Grover W. Hamilton Bel Air Md.</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
331X IMMEDIATE CAUSE (A) <u>Cerebral Vascular Accident</u>				3 months			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Generalized Arteriosclerosis</u>				6-8 yrs			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>450.0</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> el work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>March</u> , 19 <u>57</u> , to <u>June 20</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>June 20</u> , 19 <u>57</u> , and that death occurred at <u>11:54 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Dudley Phyllips Md</u>				DATE SIGNED <u>6/20/57</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				24. REC'D BY REGISTRAR <u>Priscilla Lowwood</u>			
DATE <u>6-25-57</u>				25. FUNERAL DIRECTOR'S SIGNATURE <u>Martin E. Smith</u>			

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

CERTIFICATE OF DEATH

U.S. DEPARTMENT OF HEALTH, EDUCATION AND WELFARE

1. NAME OF DECEASED: _____

2. SEX: _____ DATE OF BIRTH: _____
 3. PLACE OF BIRTH: _____
 4. OCCUPATION: _____
 5. MARITAL STATUS: _____

6. DATE OF DEATH: _____ PLACE OF DEATH: _____

7. CAUSE OF DEATH: _____

8. SIGNATURE OF PHYSICIAN: _____

9. SIGNATURE OF WITNESS: _____

10. SIGNATURE OF DECEASED: _____

11. SIGNATURE OF REGISTRAR: _____

12. SIGNATURE OF CLERK: _____

13. SIGNATURE OF CHIEF OF BUREAU: _____

14. SIGNATURE OF ASSISTANT CHIEF OF BUREAU: _____

15. SIGNATURE OF DEPUTY CHIEF OF BUREAU: _____

16. SIGNATURE OF ASSISTANT DEPUTY CHIEF OF BUREAU: _____

17. SIGNATURE OF CLERK: _____

18. SIGNATURE OF CHIEF OF BUREAU: _____

19. SIGNATURE OF ASSISTANT CHIEF OF BUREAU: _____

20. SIGNATURE OF DEPUTY CHIEF OF BUREAU: _____

This certificate is valid only when used in connection with the death of a person who is a resident of the United States or who is a citizen of the United States. It is not valid for use in connection with the death of a person who is a resident of a foreign country or who is a citizen of a foreign country.

RECEIVED
 JUN 28 1957
 BUREAU V. S.

6379

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE District of Columbia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Air				c. LENGTH OF STAY IN 1b 7 Weeks			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Harford Convalescent Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Adam Middle Albert Last Hohmes				4. DATE OF DEATH Month June Day 10 Year 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 30, 1883	
9. AGE (In years last birthday) yrs. 73		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Freight Checker				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Oscar Hohmes				14. MOTHER'S MAIDEN NAME Elizabeth Volz			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT William Alfred Hohmes, 3621 Newark, N.W., Wash.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE, terminating DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chr. Hypertensive Cardio-vascular disease DUE TO (c) Cancer of Lung PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 163X INTERVAL BETWEEN ONSET AND DEATH 30 min ?							D.C.
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from April 20 , 19 57 , to June 10 , 19 57 , that I last saw the deceased alive on June 9 , 19 57 , and that death occurred at 10:00PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Forest Hill, Maryland DATE SIGNED June 11, 1957							
ACTUAL SIGNATURE Willard P. Hudson M.D.							
PHYSICIAN'S NAME (Type) Willard P. Hudson, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/13/57		22c. NAME OF CEMETERY OR CREMATORY HOLY REDEEMER CEMETERY		22d. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE HENRY SANDER & SONS INC. BALTIMORE MD.				24a. REC'D BY REGISTRAR June 13 1957		24b. REGISTRAR'S SIGNATURE Trucilla Forwood	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1957

City of Baltimore

Residence

Age

Sex

Color

Occupation

Place of Birth

Married

Single

Widow

Spouse

Spouse

Place of Death

Place of Death

Place of Death

Signature of Physician

Signature of Physician

Time

Time

Time

Time

Time

Time

Time

BUREAU V. S.

JUN 13 1957

RECEIVED

6380

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Hartford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>32 Bel Air</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>				d. STREET ADDRESS <u>Kenmore Over</u>			
3. NAME OF DECEASED (Type or print) <u>Alice</u> First <u>Walbeck</u> Middle <u>Hopkins</u> Last				4. DATE OF DEATH <u>June</u> Month <u>20</u> Day <u>1957</u> Year			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-29-1900</u>	9. AGE (In years last birthday) <u>56</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Librarian</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Public</u>		11. BIRTHPLACE (State or foreign country) <u>Black Horse Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Adam Walbeck</u>				14. MOTHER'S MAIDEN NAME <u>Cordelia Delevette</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>714-18-3810</u>		17. INFORMANT <u>Mr Murray L. Hopkins Jr</u> Address <u>Bel Air Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Metastatic Carcinoma (Original site Ovary)</u> <u>175X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>1 Year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>Sept. 6</u> , 19 <u>56</u> , to <u>June</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>June 20</u> , 19 <u>57</u> , and that death occurred at <u>11:22 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Willard P. Hudson</u> M.D.				ADDRESS (Street, city or town, state) <u>Forest Hill, Md.</u> DATE SIGNED <u>June 20, 1957</u>			
PHYSICIAN'S NAME (Type) <u>Willard P. Hudson, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-22-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Mem Gardens</u>		22d. LOCATION (City, town, or county) (State) <u>Bel Air Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Martin G. ...</u> ADDRESS <u>...</u>				24a. REC'D BY REGISTRAR <u>...</u> DATE <u>6-25-57</u>		24b. REGISTRAR'S SIGNATURE <u>Prinella Forward</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUN 28 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6381

CERTIFICATE OF DEATH

Reg. Dist. No.

06375
183-

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harve de Grace</u>		c. LENGTH OF STAY IN 1b <u>4 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air, Md. R.D., X2</u> d. STREET ADDRESS <u>Box 358, Rt #1</u>	
3. NAME OF DECEASED (Type or print) <u>Baby Boy</u> First Middle Last <u>Kirksey</u>		4. DATE OF DEATH Month <u>June</u> Day <u>1</u> Year <u>1957</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 29, 1957</u>
9. AGE (In years last birthday) yrs. <u>4</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>4</u> Days <u>4</u> Hours <u>4</u> Min. <u>4</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Benjamin Franklin Kirksey</u>		14. MOTHER'S MAIDEN NAME <u>Marlene Valerie Ringold</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Benjamin F. Kirksey</u>		Address <u>Churchville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>754.2 Congenital Ventricular Sept</u> DUE TO <u>Congenital Intestinal Adhesions</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>4 days</u> DUE TO (c) <u>4 days</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 29, 1957</u> , to <u>June 1, 1957</u> , that I last saw the deceased alive on <u>June 1, 1957</u> , and that death occurred at <u>5:30 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Churchville, Md.</u> DATE SIGNED <u>June 1</u>			
ACTUAL SIGNATURE <u>Ralph J. Horkey</u> M.D.		PHYSICIAN'S NAME (Type) <u>Ralph J. Horkey</u> <u>Churchville, Maryland.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 3, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Asbury</u>		22d. LOCATION (City, town, or county) (State) <u>Churchville, Harford, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard L. McComas & Son</u> ADDRESS <u>Abingdon Md.</u>		24a. REC'D BY REGISTRAR DATE <u>6-4-57</u>	
24b. REGISTRAR'S SIGNATURE <u>G. L. Lewis M.D.</u>			

2071214 XV6

RECEIVED

BUREAU V. S.

6382

CERTIFICATE OF DEATH

Reg. Dist. No.

181

1. PLACE OF DEATH o. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 31 Aberdeen			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Balto. Street				d. STREET ADDRESS 1 Balto. Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First John Middle Daniel Last Lassiter				4. DATE OF DEATH Month June Day 16th. Year 19 57			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/26/1902		9. AGE (In years last birthday) 54 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Govt. APG, Dover		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Lassiter				14. MOTHER'S MAIDEN NAME Mamie Sanders			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 240-09-9076		17. INFORMANT Mrs. John Lassiter, Balto. St. Aberdeen		Address Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertension DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hemi plegia, left side DUE TO (c) Myocardial failure PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None INTERVAL BETWEEN ONSET AND DEATH 1 year 2 days 14 days							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept , 19 1956 to June , 19 57 , that I last saw the deceased alive on June 16 , 19 57 , and that death occurred at 9 A. M., from the causes and on the date stated above.							
ACTUAL SIGNATURE Joseph R. Dolce				ADDRESS (Street, city or town, state) HAVER DE GRACE, MD.			
PHYSICIAN'S NAME (Type) JOSEPH R. DOLCE				DATE SIGNED 6-17-57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 6/18/57		22c. NAME OF CEMETERY OR CREMATORY *		22d. LOCATION (City, town, or county) (State) Wilson, North Carolina	
23. FUNERAL DIRECTOR'S SIGNATURE John G. Tarring				ADDRESS Aberdeen, Md.		24a. REC'D BY REGISTRAR DATE June 18-57	
				24b. REGISTRAR'S SIGNATURE Mellie R. Perry			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

JUN 20 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06377

6397

CERTIFICATE OF DEATH

Reg. Dist. No. 180

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Abingdon		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Abingdon	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Helen Middle Louise Last Lee		4. DATE OF DEATH Month June , Day 26 , Year 19 57	
5. SEX female	6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June, 20, 1916
9. AGE (In years lost birthday) 41 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (State or foreign country) Harford Co., Md.,		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward Lee		14. MOTHER'S MAIDEN NAME Bertha Parker	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none	
17. INFORMANT Bertha Lee		Address Abingdon Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac Failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease (c) Arteriosclerotic Heart Disease			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. 11 p. m. Month, Day, Year 19 57		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/23 , 1957, to 6/26 , 1957, that I last saw the deceased alive on 6/26 , 1957, and that death occurred at 3:30 p. M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 569 Revolution St., Havre de Grace, Md 21757 DATE SIGNED June 24 1957 ACTUAL SIGNATURE George T. Stansbury, M.D. PHYSICIAN'S NAME (Type) George T. Stansbury			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June, 29, 1957	
22c. NAME OF CEMETERY OR CREMATORY John Wesley		22d. LOCATION (City, town, or county) (State) Abingdon Harford Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Edward K. McGowan		24a. REC'D BY REGISTRAR June 24 1957	
ADDRESS Abingdon Md.		24b. REGISTRAR'S SIGNATURE Norma B. Moore	

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, time, place, cause, and signature. The form is mostly blank with some faint markings.

BUREAU V. 3

JUL 2 1957

RECEIVED

6383

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06378

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jamestown</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> 1903X02		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hospital</u>			d. STREET ADDRESS <u>300 Delmar St</u>		
3. NAME OF DECEASED (Type or print) <u>Flood</u> First <u>Raymond</u> Middle <u>Miller</u> Last			4. DATE OF DEATH <u>June 24</u> 19 <u>57</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 6, 1901</u>	9. AGE (In years last birthday) <u>56</u> yrs.	10. IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FOREMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>STEEL MFR.</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>	
13. FATHER'S NAME <u>RAYMOND MILLER</u>			14. MOTHER'S MAIDEN NAME <u>EMMA</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>213-09-2144</u>		17. INFORMANT <u>MAMIE KRAMER MILLER</u> Address <u>SAME</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>crushing injury chest</u> 825X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto accident</u>			
20c. TIME OF INJURY Month, Day, Year <u>Hour 12:30 p.m. 6-21-57</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>On 55th St</u>	
				20f. (City or town) <u>Harford</u> (County) <u>Harford</u> (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <u>Gerald C Palmer</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6/27/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MEADOWBRIDGE</u>	
				22d. LOCATION (City, town, or county) <u>DORSET, MD</u> (State) <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Arthur Bradley - Kumbach 22, M</u>			24a. REC'D BY REGISTRAR <u>JUN 27 1957</u>		
			24b. REGISTRAR'S SIGNATURE <u>A. L. Lewis</u>		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 3

JUN 27 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6384

CERTIFICATE OF DEATH

06379

Reg. Dist. No. 185-

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Hartford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre-de-Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Kingsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hartford Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Frank</u> First Middle Last <u>MITCHELL</u>		4. DATE OF DEATH Month <u>6</u> Day <u>19</u> Year <u>1957</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11 APR 1894</u>
9. AGE (In years last birthday) <u>63</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CARPENTER.</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward Gross Mitchell</u>		14. MOTHER'S MAIDEN NAME <u>Florence Swartz</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT Address <u>Mrs. Charles E. Gross, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac failure</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive arteriosclerotic cardiovascular disease ~ 5 years</u> DUE TO (c) <u>—</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Circulatory insufficiency of extremities</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>May 1</u> , 19 <u>57</u> , to <u>June 12</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>June 19</u> , 19 <u>57</u> , and that death occurred at <u>10:12</u> P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Aberdeen, Md.</u> DATE SIGNED <u>6-19-57</u>			
ACTUAL SIGNATURE <u>B. J. Plunkett, Jr.</u> M.D.		DATE SIGNED <u>6-19-57</u>	
PHYSICIAN'S NAME (Type) <u>B. J. Plunkett Jr.</u>		ADDRESS <u>Aberdeen - Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BORIAL</u>	22b. DATE THEREOF <u>21 JUNE 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>BEL AIR MEMORIAL PARK</u>	22d. LOCATION (City, town, or county) (State) <u>BEL AIR, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Madison Mitchell</u> ADDRESS <u>Harre-de-Grace, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>6-21-57</u>	24b. REGISTRAR'S SIGNATURE <u>G. L. Remis m. l.</u>

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

Page No. 1

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

DATE OF DEPARTURE

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

BUREAU V. S.

JUN 24 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06380

6398

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL BELAIR</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X1 RURAL NORRISVILLE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD CO. HOME</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>JENNIE E. MOXLEY</u>				4. DATE OF DEATH Month Day Year <u>6-25-1957</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-20-1876</u>	
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>NORTH CAROLINA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>GEORGE MADE</u>				14. MOTHER'S MAIDEN NAME <u>MARTHA SMITH</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT <u>George Moxley</u>				Address <u>Fawn Grove Rd, Pa.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic hypertensive cardio-vascular disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>331X</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>May 4, 1957</u> , to <u>June 25, 1957</u> , that I last saw the deceased alive on <u>June 23, 1957</u> , and that death occurred at <u>3 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Willard P. Hudson</u>				ADDRESS (Street, city or town, state) <u>Forest Hill, Maryland</u>			
DATE SIGNED <u>June 25, 1957</u>							
PHYSICIAN'S NAME (Type) <u>Willard P. Hudson</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-27-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Marion Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Marion, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Kenneth W. Hudson</u>				ADDRESS <u>Stewartstown, Pa.</u>		24a. REC'D BY REGISTRAR <u>6-28-57</u>	
24b. REGISTRAR'S SIGNATURE <u>Priscilla Howard</u>							

BUREAU V. S.

107 2 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6385

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

06381
1802

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Pa b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Air		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MCCOY TOWN 75 X-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First ROBERT Middle T Last PEAVORNICK		4. DATE OF DEATH Month JUNE Day 8 Year 1957	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAR 8-1929
9. AGE (In years last birthday) 28 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) State Clerk		10b. KIND OF BUSINESS OR INDUSTRY Pc	
11. BIRTHPLACE (State or foreign country) Pc		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME John Peavornick		14. MOTHER'S NAME Anna Valencic	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 1 NO		16. SOCIAL SECURITY NO. 163-24-6506	
17. INFORMANT ANTHONY KAPRICK Funeral Home		18. ADDRESS MCCOY TOWN PA	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGENITAL HEART DISEASE 754.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE R. S. Fisher		M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) R. S. FISHER		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 12/57	
22c. NAME OF CEMETERY OR CREMATORY St Agnes Cemetery		22d. LOCATION (City, town, or county) (State) Lockport Pa	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Fisher		ADDRESS Bel Air Md	
24a. REC'D BY REGISTRAR DATE 6-10-57		24b. REGISTRAR'S SIGNATURE Charles Foxwood	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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JUN 12 1957
BUREAU V. S.

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06382

6386

CERTIFICATE OF DEATH

Reg. Dist. No.

181

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 276 Paradise Road		d. STREET ADDRESS #276 Paradise Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Frank Middle Andrew Last Preston		4. DATE OF DEATH Month 6 Day 20 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 23rd. 1874
9. AGE (In years past birthday) yrs. 82		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Canner-Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Retired Employed	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME J. Henry Preston		14. MOTHER'S MAIDEN NAME Eliza Cullum	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-03-8767	
17. INFORMANT Stewart Preston		Address Md. 46 Paradise Rd. Aberdeen	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure DUE TO Arteriosclerotic Heart Dis. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Chronic cystitis, severe (b) Coronary Arteriosclerosis (c) Chronic cystitis, severe		INTERVAL BETWEEN ONSET AND DEATH Terminal 5 yr. 5 yr.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 6-20-57 , 19 55 , to 6-20- , 19 57 , that I last saw the deceased alive on 6-20-57 , and that death occurred at 11:25 AM , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 8 Law St, Aberdeen, Md. DATE SIGNED 6-21-57	
ACTUAL SIGNATURE Peter P. Rooman, M.D.		PHYSICIAN'S NAME (Type) Peter P. Rooman, M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/23/57	
22c. NAME OF CEMETERY OR CREMATORY Wesleyan Chapel Cem.		22d. LOCATION (City, town, or county) (State) Aberdeen RD, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John G. Tarring, Aberdeen, Md.		24a. REC'D BY REGISTRAR DATE 6-23-57	
24b. REGISTRAR'S SIGNATURE Marie R. Perry			

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
John Doe		Male		45		1910		Maryland		Baltimore		Heart Disease		June 25, 1957		10:00 AM		Home		J. A. Smith		M. B. Jones	
Occupation		Married		Single		Widowed		Divorced		Last Known Address		Previous Address		Previous Address		Previous Address		Previous Address		Previous Address		Previous Address	
John Doe		Male		45		1910		Maryland		Baltimore		Heart Disease		June 25, 1957		10:00 AM		Home		J. A. Smith		M. B. Jones	
Occupation		Married		Single		Widowed		Divorced		Last Known Address		Previous Address		Previous Address		Previous Address		Previous Address		Previous Address		Previous Address	

BUREAU V. 2

JUN 25 1957

RECEIVED

6399

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE MD. b. COUNTY HARFORD			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL STREET				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL STREET			
c. LENGTH OF STAY IN 1b 3 yrs.				d. STREET ADDRESS R.D. #1			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.D. #1				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MARY Middle MARTORIE Last REYNOLDS				4. DATE OF DEATH Month JUNE Day 12 Year 1957			
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MAY 28, 1899	
9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTH PLACE (State or foreign country) YORK CO., PA.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME ELMER HEAPS				14. MOTHER'S MAIDEN NAME MARGARET STEWART			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address WM. REYNOLDS, STREET R.D. #1, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Uterus 174X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 6 mos. DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from June 11, 1957 , to June 12, 1957 , that I last saw the deceased alive on June 11, 1957 , and that death occurred at 10:30 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Nosiah A. Hunt M.D.				ADDRESS (Street, city or town, state) Delta, Pa.		DATE SIGNED 6/13/57	
PHYSICIAN'S NAME (Type) Nosiah A. Hunt				Delta, Pa.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6-15-57		22c. NAME OF CEMETERY OR CREMATORY MT. NEO		22d. LOCATION (City, town, or county) (State) DELTA R.D., PA.	
23. FUNERAL DIRECTOR'S SIGNATURE John H. Harkins ADDRESS Delta, Pa.				24a. REC'D BY REGISTRAR DATE 6-14-57		24b. REGISTRAR'S SIGNATURE Prueilla Lowndes	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BAGLIDORE 18

NAME OF DECEASED <i>John Doe</i>		DATE OF BIRTH <i>Jan 1, 1900</i>	
PLACE OF BIRTH <i>John Doe</i>		DATE OF DEATH <i>Jan 1, 1957</i>	
SEX <i>Male</i>		AGE <i>57</i>	
MARRIAGE <i>Married</i>		CAUSE OF DEATH <i>Heart Disease</i>	
OCCUPATION <i>Teacher</i>		PLACE OF DEATH <i>Home</i>	
EDUCATION <i>High School</i>		DATE OF INTERMENT <i>Jan 1, 1957</i>	
RELIGION <i>Methodist</i>		PLACE OF INTERMENT <i>St. John's Church</i>	
MANNER OF DEATH <i>Natural</i>		DATE OF REPORT <i>Jan 1, 1957</i>	
REPORTED BY <i>John Doe</i>		DATE OF SIGNATURE <i>Jan 1, 1957</i>	
SIGNATURE OF REPORTER <i>John Doe</i>		SIGNATURE OF PHYSICIAN <i>John Doe</i>	
SIGNATURE OF CLERK <i>John Doe</i>		SIGNATURE OF JUDGE <i>John Doe</i>	

BUREAU V. 1

JUN 18 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6387 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 180

06384

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harwood Grace</u>		c. LENGTH OF STAY IN 1b <u>1 hour</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgewood R.D.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>James Albert Sills Jr.</u>		4. DATE OF DEATH Month Day Year <u>June 24 1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July, 9, 1930</u>
9. AGE (in years last birthday) <u>17</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Car Washer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Automobile</u>	
11. BIRTHPLACE (State or foreign country) <u>Harford Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James A. Sills</u>		14. MOTHER'S MAIDEN NAME <u>Helen V. Harmon</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>214-36-8511</u>	
17. INFORMANT <u>James A. Sills,</u>		Address <u>Edgewood R.D., Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture skull</u> 819x DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto accident auto-object type</u>	
20c. TIME OF INJURY Month, Day, Year Hour m. p. m. <u>9 6-24 57</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Willoughby Rd Edgewood Harford Md</u>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Gerald Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Harford Co.</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>6-25-57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>June 28, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's</u>	22d. LOCATION (City, town, or county) (State) <u>Edgewood, Harford, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard E. Williams Jr.</u>		ADDRESS <u>Abingdon Md.</u>	
24. REC'D BY REGISTRAR <u>June 29, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Norma E. Moore</u>	

RECEIVED

JUL 2 1957

BUREAU V. S.

6388

CERTIFICATE OF DEATH

Reg. Dist. No.

185

1. PLACE OF DEATH o. COUNTY <i>Harford</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Harford</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harre de Grace</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>24 Harre de Grace</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <i>Harford Memorial Hosp.</i>				e. STREET ADDRESS <i>1508 St. Lewis St.</i>			
3. NAME OF DECEASED (Type or print) <i>Phillip Henry (Harry) Tasco</i>				4. DATE OF DEATH Month <i>6</i> Day <i>28</i> Year <i>1957</i>			
5. SEX <i>Male</i>		6. COLOR OR RACE <i>Negro</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <i>3-11-1868</i>	
9. AGE (In years last birthday) <i>89</i> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Postal Employee (Retired) Post Office</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Louis Tasco</i>				14. MOTHER'S MAIDEN NAME <i>Rebecca Richardson</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Mrs. Helen Cook</i> Address <i>26-41-98th Street East Elmhurst, N.Y.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Intestinal Obstruction</i> <i>561.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>R. indirect inguinal hernia</i> DUE TO <i>strangulated</i> (c) _____						INTERVAL BETWEEN ONSET AND DEATH <i>8 days</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <i>6/12</i> , 19 <i>57</i> , to <i>6/28</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>6/28</i> , 19 <i>57</i> , and that death occurred at <i>2:00</i> P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>W H Sadowsky</i> M.D. <i>600 S Union St.</i>				ADDRESS (Street, city or town, state) <i>Harre de Grace, Md.</i> DATE SIGNED <i>7/1/57</i>			
PHYSICIAN'S NAME (Type) <i>Wallace H. Sadowsky, M.D.</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>7-1-57</i>		22c. NAME OF CEMETERY OR CREMATORY <i>St. James Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Harre de Grace, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Otelia J. Bullock</i> ADDRESS <i>Harre de Grace</i>				24a. REC'D BY REGISTRAR <i>J. Del.</i> DATE <i>7-1-57</i>		24b. REGISTRAR'S SIGNATURE <i>G. L. Lewis M.D.</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple fields for death certificate information, including name, date, and location. The text is mostly illegible due to blurriness.

BUREAU V. 31

3 1957

RECEIVED

Form with fields for administrative use, including checkboxes and dates. The text is mostly illegible due to blurriness.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06386

6389 CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>HARFORD</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>BE AIR RD. - Schucks Corner</u>		LENGTH OF STAY (in this place) <u>11 YEARS</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>BE AIR RD. - Schucks Corner</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Churchville Road</u>				STREET ADDRESS (If rural give location) <u>Churchville Road</u>			
3. NAME OF DECEASED (Type or Print) <u>William L. Tharpe</u>				4. DATE OF DEATH <u>JUNE 12, 1957</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>		8. DATE OF BIRTH <u>July 1, 1904</u>	
				9. AGE last birthday <u>52</u> yrs.		10. IF UNDER 1 YEAR: Months Days	
						11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMING</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>AGRICULTURE</u>		11. BIRTHPLACE (State or foreign country) <u>RONDA, NORTH CAROLINA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>BENJAMIN L. THARPE</u>				14. MOTHER'S MAIDEN NAME <u>DORA THORNTON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>216-09-2237</u>		17. INFORMANT & ADDRESS <u>BE AIR RD #1; MRS. MABEL Charlotte Tharpe, Maryland</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						15. MEDICAL CERTIFICATION	
420.1 IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 hrs</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B)							
DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12 June, 1957</u> , to <u>12 June, 1957</u> , that I last saw the deceased alive on <u>12 June, 1957</u> , and that death occurred at <u>2:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Priscilla Foxwood</u> M.D.				ADDRESS (Street, city, town, state) <u>Bel Air, Md.</u> DATE SIGNED <u>12 June '57</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>JUNE 15, 1957</u>		NAME OF CEMETERY OR CREMATORY <u>Mt. Zion</u>		LOCATION (City, town, or county) (State) <u>Fountain Green, Harf. Co., Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Priscilla Foxwood</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph William Foster, 132 Broadway, Bel Air, Md.</u>			
DATE <u>6-13-57</u>							

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12

CERTIFICATE OF DEATH

COUNTY OF BALTIMORE CITY OF BALTIMORE		DEPARTMENT OF HEALTH BALTIMORE	
NAME OF DECEASED BERNARD L. THORNTON		SEX Male	
DATE OF DEATH June 14, 1957		PLACE OF DEATH Home	
TIME OF DEATH 11:00 AM		CAUSE OF DEATH (To be filled by physician)	
SIGNATURE OF DECEASED (If living)		SIGNATURE OF PHYSICIAN (To be filled by physician)	
SIGNATURE OF WITNESSES (To be filled by witnesses)		SIGNATURE OF REGISTRAR (To be filled by registrar)	

BUREAU V. 2

JUN 14 1957

RECEIVED

THIS IS A COPY OF THE ORIGINAL RECORD OF DEATH, AND IS NOT TO BE USED FOR ANY OTHER PURPOSE. IT IS THE PROPERTY OF THE DEPARTMENT OF HEALTH, AND IS TO BE RETURNED TO THE DEPARTMENT OF HEALTH, BALTIMORE, MARYLAND, UPON REQUEST.

6390

CERTIFICATE OF DEATH

Reg. Dist. No.

06387

1. PLACE OF DEATH o. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>90 Harford Convalescent Home</u>				d. STREET ADDRESS <u>1 AFD</u>			
3. NAME OF DECEASED (Type or print) <u>Malcolm V Tyson</u>				4. DATE OF DEATH <u>June 24 1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 20, 1873</u>	9. AGE (In years last birthday) <u>83</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lawyer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <u>FRED. TYSON</u>				14. MOTHER'S MAIDEN NAME <u>FLORENCE ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>Joseph Hunt Catonsville Md</u>			
17. INFORMANT <u>Joseph Hunt Catonsville Md</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic & V disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <u>2 mo</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>4-24</u> 19 <u>57</u> to <u>6-24</u> 19 <u>57</u> , that I last saw the deceased alive on <u>6-18</u> 19 <u>57</u> , and that death occurred at <u>6:54</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Gerald E Palmer</u> M.D.				ADDRESS (Street, city or town, state) <u>Bel Air Md</u>			
DATE SIGNED <u>6-24-57</u>							
PHYSICIAN'S NAME (Type) <u>Gerald E. Palmer M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/26/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Greenmount</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Mac Nabbs & Son</u>				ADDRESS <u>Caton. 28</u>		24a. REC'D BY REGISTRAR <u>June 27 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>Wesley A. Howard</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JUN 27 1957

BUREAU V. S.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

1

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06388

6400 CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Hartford</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>Hartford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Uppa Rural</u>		LENGTH OF STAY (in this place) <u>2 years</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>XO Toppa RD</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Bessie</u> (Middle) <u>V</u> (Last) <u>Walker</u>				(Month) <u>6</u> (Day) <u>19</u> (Year) <u>1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, ENGAGED , (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Jan - 1873</u>	9. AGE last birthday <u>84</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Hartford</u>	12. CITIZEN OF WHAT COUNTRY? <u>US</u>		
13. FATHER'S NAME <u>Wm Minnick</u>				14. MOTHER'S MAIDEN NAME <u>Sallie Haughey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Willie E. Grifton</u> <u>Toppa, MD</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
332X IMMEDIATE CAUSE (A) <u>Cerebral thrombosis</u>				10 days			
ANTECEDENT CAUSE(S) DUE TO (B) <u>arterial sclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Thrombosis at popliteal artery</u>				5 days			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June 10, 1957</u> , to <u>June 19, 1957</u> , that I last saw the deceased alive on <u>June 19, 1957</u> , and that death occurred at <u>5:45 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Red O'Hodous</u>		M. D. <u>Edgewood Md</u>		DATE SIGNED <u>6-19-57</u>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>Jan 21/57</u>		NAME OF CEMETERY OR CREMATORY <u>Centre Methodist</u>		LOCATION (City, town, or county) (State) <u>Forest Hill Md</u>	
24. REC'D BY REGISTRAR <u>Priscilla Leonard</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph T. L...</u>		ADDRESS <u>Pell Cui. Md</u>	
DATE <u>6-19-57</u>							

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

JUN 21 1957

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06389

6401

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH o. COUNTY <i>Harford</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Harford</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Street</i>	c. LENGTH OF STAY IN 1b <i>Lifetime</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Street</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Rt # 2 Box 115</i>		d. STREET ADDRESS <i>Rt # 2 Box 115</i>	
3. NAME OF DECEASED (Type or print) First <i>Margaret</i> Middle <i>Hatters</i> Last <i>Hatters</i>		4. DATE OF DEATH Month <i>6</i> Day <i>29</i> Year <i>1957</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12-18-1883</i>
9. AGE (In years last birthday) <i>74 yrs.</i>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>William Kenly</i>		14. MOTHER'S MAIDEN NAME <i>Mary Jane Kenly</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <i>no</i>		16. SOCIAL SECURITY NO. <i>none</i>	
17. INFORMANT <i>Mrs. Sarah Barnes</i>		Address <i>Rt 2 Box 115 Street, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> <i>443X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypertensive Cardio Vascular Disease</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>331X Scurvy</i>			INTERVAL BETWEEN ONSET AND DEATH <i>15 days</i> <i>Prob. 20 yrs</i>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>4/1/1950</i> , to <i>6/29/1957</i> , that I last saw the deceased alive on <i>6/26/1957</i> , and that death occurred at <i>10:45 A.M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Robert Barthel</i>		ADDRESS (Street, city or town, state) <i>Forest Hill, Maryland</i>	
PHYSICIAN'S NAME (Type) <i>Robert Barthel</i>		DATE SIGNED <i>7/1/57</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>7-2-57</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Clark's Chapel Cem.</i>	22d. LOCATION (City, town, or county) (State) <i>Galmar, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Charles J. Bullock</i>		ADDRESS <i>Hare de Guay</i>	24a. REC'D BY REGISTRAR DATE <i>7-1-57</i>
		24b. REGISTRAR'S SIGNATURE <i>Priscilla Foreman</i>	

13

1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6402

CERTIFICATE OF DEATH

06390

Reg. Dist. No. 182

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY HARFORD			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL PYLESVILLE				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X1 RURAL PYLESVILLE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First POE Middle H. Last WOODS				4. DATE OF DEATH Month JUNE Day 13 Year 1957			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-25-1896	9. AGE (In years last birthday) 60 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WATCHMAN				10b. KIND OF BUSINESS OR INDUSTRY SEWING FACTORY		11. BIRTHPLACE (State or foreign country) W. VIRGINIA	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME LEMASTERS WOODS				14. MOTHER'S MAIDEN NAME AMANDA KELLERSON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT 333 1682 & 4 Florence Woods Fawn Grove, Pa.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X Cerebral Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arterio sclerosis DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 4 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 450.0				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from June 10, 1957 , to June 13, 1957 , that I last saw the deceased alive on June 13, 1957 , and that death occurred at 11:57 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Edward W. Hason M.D.				ADDRESS (Street, city or town, state) Fawn Grove, Pa. DATE SIGNED 6/14/57			
PHYSICIAN'S NAME (Type) Edward W. Hason				Fawn Grove, Pa.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		6-16-57		FRIENDSHIP		PYLESVILLE, HARFORD CO., MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Edward Hason				ADDRESS Fawn Grove, Pa.		24a. REC'D BY REGISTRAR DATE 6-17-57	
				24b. REGISTRAR'S SIGNATURE Bucilla Lowwood			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS
CERTIFICATE OF DEATH

1. NAME OF DECEASED [Faint text]		2. SEX [Faint text]	
3. AGE [Faint text]		4. DATE OF BIRTH [Faint text]	
5. PLACE OF BIRTH [Faint text]		6. OCCUPATION [Faint text]	
7. MARITAL STATUS [Faint text]		8. CAUSE OF DEATH [Faint text]	
9. PLACE OF DEATH [Faint text]		10. TIME OF DEATH [Faint text]	
11. SIGNATURE OF DECEASED [Faint text]		12. SIGNATURE OF WITNESS [Faint text]	
13. SIGNATURE OF PHYSICIAN [Faint text]		14. SIGNATURE OF CLERK [Faint text]	
15. SIGNATURE OF REGISTRAR [Faint text]		16. SIGNATURE OF DECEASED [Faint text]	
17. SIGNATURE OF WITNESS [Faint text]		18. SIGNATURE OF PHYSICIAN [Faint text]	
19. SIGNATURE OF CLERK [Faint text]		20. SIGNATURE OF REGISTRAR [Faint text]	
21. SIGNATURE OF DECEASED [Faint text]		22. SIGNATURE OF WITNESS [Faint text]	
23. SIGNATURE OF PHYSICIAN [Faint text]		24. SIGNATURE OF CLERK [Faint text]	
25. SIGNATURE OF REGISTRAR [Faint text]		26. SIGNATURE OF DECEASED [Faint text]	
27. SIGNATURE OF WITNESS [Faint text]		28. SIGNATURE OF PHYSICIAN [Faint text]	
29. SIGNATURE OF CLERK [Faint text]		30. SIGNATURE OF REGISTRAR [Faint text]	
31. SIGNATURE OF DECEASED [Faint text]		32. SIGNATURE OF WITNESS [Faint text]	
33. SIGNATURE OF PHYSICIAN [Faint text]		34. SIGNATURE OF CLERK [Faint text]	
35. SIGNATURE OF REGISTRAR [Faint text]		36. SIGNATURE OF DECEASED [Faint text]	
37. SIGNATURE OF WITNESS [Faint text]		38. SIGNATURE OF PHYSICIAN [Faint text]	
39. SIGNATURE OF CLERK [Faint text]		40. SIGNATURE OF REGISTRAR [Faint text]	
41. SIGNATURE OF DECEASED [Faint text]		42. SIGNATURE OF WITNESS [Faint text]	
43. SIGNATURE OF PHYSICIAN [Faint text]		44. SIGNATURE OF CLERK [Faint text]	
45. SIGNATURE OF REGISTRAR [Faint text]		46. SIGNATURE OF DECEASED [Faint text]	
47. SIGNATURE OF WITNESS [Faint text]		48. SIGNATURE OF PHYSICIAN [Faint text]	
49. SIGNATURE OF CLERK [Faint text]		50. SIGNATURE OF REGISTRAR [Faint text]	
51. SIGNATURE OF DECEASED [Faint text]		52. SIGNATURE OF WITNESS [Faint text]	
53. SIGNATURE OF PHYSICIAN [Faint text]		54. SIGNATURE OF CLERK [Faint text]	
55. SIGNATURE OF REGISTRAR [Faint text]		56. SIGNATURE OF DECEASED [Faint text]	
57. SIGNATURE OF WITNESS [Faint text]		58. SIGNATURE OF PHYSICIAN [Faint text]	
59. SIGNATURE OF CLERK [Faint text]		60. SIGNATURE OF REGISTRAR [Faint text]	
61. SIGNATURE OF DECEASED [Faint text]		62. SIGNATURE OF WITNESS [Faint text]	
63. SIGNATURE OF PHYSICIAN [Faint text]		64. SIGNATURE OF CLERK [Faint text]	
65. SIGNATURE OF REGISTRAR [Faint text]		66. SIGNATURE OF DECEASED [Faint text]	
67. SIGNATURE OF WITNESS [Faint text]		68. SIGNATURE OF PHYSICIAN [Faint text]	
69. SIGNATURE OF CLERK [Faint text]		70. SIGNATURE OF REGISTRAR [Faint text]	
71. SIGNATURE OF DECEASED [Faint text]		72. SIGNATURE OF WITNESS [Faint text]	
73. SIGNATURE OF PHYSICIAN [Faint text]		74. SIGNATURE OF CLERK [Faint text]	
75. SIGNATURE OF REGISTRAR [Faint text]		76. SIGNATURE OF DECEASED [Faint text]	
77. SIGNATURE OF WITNESS [Faint text]		78. SIGNATURE OF PHYSICIAN [Faint text]	
79. SIGNATURE OF CLERK [Faint text]		80. SIGNATURE OF REGISTRAR [Faint text]	
81. SIGNATURE OF DECEASED [Faint text]		82. SIGNATURE OF WITNESS [Faint text]	
83. SIGNATURE OF PHYSICIAN [Faint text]		84. SIGNATURE OF CLERK [Faint text]	
85. SIGNATURE OF REGISTRAR [Faint text]		86. SIGNATURE OF DECEASED [Faint text]	
87. SIGNATURE OF WITNESS [Faint text]		88. SIGNATURE OF PHYSICIAN [Faint text]	
89. SIGNATURE OF CLERK [Faint text]		90. SIGNATURE OF REGISTRAR [Faint text]	
91. SIGNATURE OF DECEASED [Faint text]		92. SIGNATURE OF WITNESS [Faint text]	
93. SIGNATURE OF PHYSICIAN [Faint text]		94. SIGNATURE OF CLERK [Faint text]	
95. SIGNATURE OF REGISTRAR [Faint text]		96. SIGNATURE OF DECEASED [Faint text]	
97. SIGNATURE OF WITNESS [Faint text]		98. SIGNATURE OF PHYSICIAN [Faint text]	
99. SIGNATURE OF CLERK [Faint text]		100. SIGNATURE OF REGISTRAR [Faint text]	

RECEIVED
JUN 19 1957
BUREAU V. S.